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Issue Date: 29 October 2003

CASE NO.: 2003-LHC-1016

OWCP NO.: 07-108068

IN THE MATTER OF

VERNELL SIMMONS,
Claimant

v.

FREEPORT SULPHUR CO.,
Employer

and

LIBERTY MUTUAL INSURANCE,
Carrier

APPEARANCES:

BOBBY G. O'BARR, ESQ.
On behalf of the Claimant

Before: LARRY W. PRICE
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (herein the Act), 33 U.S.C. § 901, et seq., brought by Vernell Simmons (Claimant) against Freeport Sulphur Co. (Employer) and Liberty Mutual Insurance (Carrier).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. A formal hearing was held in Gulfport, Mississippi, on September 17, 2003. All parties were afforded a full opportunity to adduce testimony and offer documentary evidence. Claimant testified and offered fourteen exhibits which were admitted into evidence. Although Carrier was notified of the hearing, Carrier failed to appear at the hearing and submit evidence.

At the hearing, the Court noted that a copy of the Notice of Hearing had been served on Employer and on Carrier, attention Bill Olds, on May 8, 2003. Claimant's counsel stated that he had participated in an informal conference by phone with Mr. Olds, but Mr. Olds never responded to the claims examiner's recommendation. After receiving the Notice of Hearing, Claimant's counsel filed a request for production of documents of the Employer/Carrier regarding certain records in their claims file. Mr. Olds never responded to the request. On August 14, 2003, Claimant's counsel filed a Motion to Compel Discovery. Once again, there was no response from Carrier. On September 2, 2003, Claimant's counsel sent Mr. Olds a copy of his witness list and his exhibit list as well as the proposed joint stipulation, which he asked Mr. Olds to execute and submit to the Court. On September 4, 2003, Claimant's counsel sent Mr. Olds a copy of all his exhibits. Mr. Olds did not respond to either of these mailings. In addition, the Court noted that on the day before the hearing, the Court's office had contacted Mr. Olds specifically in regard to Claimant's case and had told Mr. Olds that the hearing was being held the following day.

On September 22, 2003, the Court issued an Order to Show Cause why the Court should not proceed with a decision based on the record presented at the hearing. On October 6, 2003, Carrier responded with a request to be given the opportunity to retain counsel and respond to the issues raised at the hearing. On October 8, 2003, Claimant objected to any further delay in the matter.

In Carrier's response to the Order to Show Cause, Carrier's representative stated that she had recently been assigned Claimant's case file. The file did not contain much information, and she did not know why Claimant's file was not sent to counsel. Carrier's representative explained that the adjuster who was previously handling Claimant's file (presumably Mr. Olds) "was very overwhelmed and is no longer with the company." In Claimant's response to Carrier's letter, Claimant's counsel again recounted the numerous instances in which Carrier simply did not respond during the various stages of the claims process, until the Order to Show Cause was issued. Claimant's counsel argued that Carrier's conduct is unreasonable and has caused delay and harm to Claimant.

I agree with Claimant that Carrier's failure to respond to any of Claimant's motions or the Court's notices or orders until the Order to Show Cause was issued after the hearing is unreasonable. Carrier's representative's attempt to excuse these actions is

simply inadequate given the circumstances. I find that there is no cause to excuse Carrier's failure to participate in the hearing process, and I will make my decision in this case based on the record submitted at the hearing.

I. ISSUES

The unresolved issues in this proceeding are:

1. Causation.

2. Date of maximum medical improvement.

3. Nature and extent of disability.

4. Rate of compensation after August 9, 1994 and September 11, 1998.

5. Section 7 medical benefits, including mileage and treatment with a neurosurgeon.

II. STATEMENT OF THE CASE

Claimant's Testimony

Claimant is a forty-three year old man who resides in McComb, Mississippi. (Tr. 13). He is a high school graduate and studied auto mechanics at a junior college. (Tr. 16). Before working for Employer, he worked in a textile mill as a frame operator and was employed at a car dealership, where he washed cars, swept floors and emptied garbage cans. Claimant testified that the frame operator job required heavy lifting, bending and stooping. (Tr. 16-17).

Claimant began working for Employer on February 24, 1981. At the time of his injury, Claimant was a rig helper/derrick relief hand. He explained that Employer is a company which mines sulphur out of the Gulf of Mexico. (Tr. 14). Claimant's job required him to move, connect and disconnect pipes from the drill. These tasks involved strenuous heavy lifting. (Tr. 15). The slips which held the pipes into the hold weighed between seventy-five and 100 pounds, and the tongs that wrapped around the drill pipe weighed between 150 and 250 pounds. (Tr. 14-15). The drilling fluid which the employees had to mix was contained in 100-pound sacks, with thirty to thirty-six packs in a pallet. Claimant testified that sometimes it took four to five pallets to mix a pit of drilling fluid. (Tr. 15). The employees worked on a wooden deck platform with heavy, galvanized-steel manholes. Claimant testified that he worked twelve hours a day, and his job was hard work, which required bending, frequent reaching and lifting. (Tr. 16).

On August 4, 1986, Claimant sustained a workplace injury when he was lifting a 100-pound sack of chemicals and his back popped. (Tr. 17-19). Claimant felt sharp pain in his low back and down his left side as well as neck pain, and he fell to the deck. Claimant reported the incident to his foreman and went to see a doctor. Claimant testified that January 1987 was the first time he missed any work as a result of the accident. (Tr. 19). He affirmed that Employer paid him full salary for fourteen weeks after his injury and then put him on fourteen weeks of half-pay before eventually paying him short-term disability. (Tr. 19-20). Claimant affirmed that Employer first paid him compensation at a rate of $447.09, commencing on January 3, 1987. (Tr. 20). Claimant returned to work on light duty from May to October 1987, running errands and acting as a gopher. (Tr. 20-21). Claimant affirmed that Employer reduced his compensation rate to $337.75 per week on August 9, 1994, without providing a reason for the reduction. On September 11, 1998, Employer reduced Claimant's compensation to $205.22 per week, once again without providing an explanation. (Tr. 20).

After his injury, Claimant treated with Dr. Alva Dillon, an internist, until May 23, 1991. Dr. Dillon referred Claimant to Dr. John Neill, who performed a laminectomy and a lumbar discectomy at L5-S1 on the left side in February 1987. (Tr. 21). After the surgery, Claimant's doctor put him on a walking plan and gave him exercises and stretches to do. Shortly thereafter, Claimant suffered a recurrence of his pre-surgery symptoms while walking, and the doctor told him to stop walking and doing the exercises. Dr. Neill eventually referred Claimant back to Dr. Dillon. Dr. Dillon never returned Claimant to work. (Tr. 22). In August 1989, Carrier sent Claimant to see Dr. Thomas Hewes, an orthopedic surgeon. (Tr. 23). Claimant affirmed that on January 17, 1990, Dr. Dillon informed Carrier that Claimant was permanently and totally disabled. (Tr. 22-23).

Claimant treated with Dr. Antronette McKenzie sometime in 1993-1994. He testified that she examined him, prescribed pain medication and might have ordered a spinal tap. Claimant affirmed that Dr. McKenzie recommended a cervical MRI. (Tr. 23). Claimant testified that his x-rays confirmed his subjective complaints since the accident. Claimant affirmed that he treated with Dr. Zina Lee from August 1994 through June 10, 1999, for back, neck and shoulder pain. During this time, he underwent an epidural and was referred to Dr. Edward Kaplan, a neurosurgeon and Dr. Rahul Vohra, a pain management specialist.

Claimant testified that he first saw Dr. Robert Smith, a neurosurgeon, around 1993. (Tr. 24). Dr. Smith performed two surgeries on Claimant, including a cervical discectomy at C5-6 on March 17, 2000, and a discectomy at L5-S1 on the right side on February 6, 2002. (Tr. 25). Claimant affirmed that the cervical discectomy involved a bone graft fusion, which has never healed. (Tr. 26). Dr. Smith continued to treat Claimant until May 2003, when he passed away. (Tr. 25).

Claimant began drawing Social Security disability since June 11, 1991. (Tr. 25-26). He was paid Social Security benefits retroactive to October 14, 1987, and his disability payments were continued on June 2, 1989. He continues to receive Social Security benefits at the present time. He testified that at the present time, he is in constant pain with regard to his neck and back and does not have the same use and activity of his limbs as a normal person of his age would. (Tr. 26). Claimant stated that before his accident, he was healthy and kept himself in shape. Now, however, Claimant's constant pain, which keeps him from enjoying activities with his family, is a source of depression. (Tr. 27).

Claimant testified that he continues to have left hip pain and that his x-rays indicate that he has herniated discs and bone spurs, yet Carrier has failed to refer him to another doctor since Dr. Smith passed away. (Tr. 27-28). Claimant affirmed that he also suffers from neck and shoulder pain, left leg cramps and numbness and tingling in his arms and hands, especially on the left side. (Tr. 28). He has used a cane since his first surgery due to the weakness in his left leg. (Tr. 28-29). Claimant has had difficulty sleeping at night and is unable to do strenuous physical activities. He is also unable to drive a car for long periods of time due to his low back condition. (Tr. 29). Claimant has requested authorization from Carrier to treat with a neurosurgeon of his choice. (Tr. 34-36).

Medical Evidence

Medical Records of Walter R. Neill, M.D. and John C. Neill, M.D.

On August 17, 1987, Dr. Walter Neill saw Claimant for a follow up appointment in Dr. John Neill's absence. Claimant had returned to work on the offshore rig on May 3, 1987, after the removal of a ruptured intervertebral disc on the left side. Claimant told Dr. W. Neill that he had been doing fine at work until the previous week, when he was coming out of a hole and began to have low back and left leg pain and had to leave work. Upon physical examination, Dr. W. Neill found nothing remarkable and concluded that Claimant did not have any severe complications and should be able to return to work after he recovered from his episode.

On August 24, 1987, Dr. John Neill saw Claimant, who complained of continued pain in his back and left calf, as well as pain in his neck and left shoulder. Claimant had recently returned to work after a vacation when his leg and back pain increased. After examining Claimant, Dr. J. Neill found nothing to suggest a recurrent disc herniation and opined that Claimant's pain was related to his being out of shape. He advised Claimant to continue working and put up with the discomfort until he got back into shape. Dr. J. Neill felt that there were no physical activities that Claimant could do to improve his situation but that once he got back into shape, his pain complaints would resolve. Because Claimant was anxious, Dr. J. Neill suggested that perhaps Claimant should seek

another form of employment. He planned to see Claimant again in two months. (CX. 7, p. 42).

Medical Records of Alva Dillon, Jr., M.D.

June 2, 1989 Letter

In this letter to Claimant's attorney, Dr. Dillon, an internist, reviewed Claimant's situation, noting that Claimant had been in persistent pain since his February 1987 surgery. Claimant had been seen by two neurosurgeons, Dr. J. Neill and Dr. Kergis, who both felt that conservative treatment should be attempted. Dr. Dillon reported that despite the conservative treatment, Claimant's condition had not improved. Dr. Dillon felt that Claimant had reached maximum medical improvement (MMI) but that Claimant probably needed another surgery. Dr. Dillon opined that Claimant was unable to return to his previous employment, even with restrictions. Dr. Dillon stated that Claimant was unable to work at a job which required lifting, bending, squatting, pulling or any tension or stress on his lower back. (CX. 1, p. 23).

October 25, 1990 Letter

In another letter to Claimant's attorney, Dr. Dillon reviewed the history of Claimant's injury and subsequent treatment, noting that Claimant's most recent MRI scan, taken on July 27, 1989, had indicated a significant amount of scar tissue surrounding a disc area as well as a small bulge in the L4-5 disc area. Dr. Dillon opined that Claimant was permanently and totally disabled for any and all forms of gainful employment, particularly in regard to his educational level. Dr. Dillon observed that Claimant was unable to do any work requiring bending, prolonged standing, stooping, sitting, reaching or lifting. Dr. Dillon expected Claimant's limitations to be continuous. (CX. 1, p. 2).

January 17, 1991 Letter

In a letter to Carrier, dated January 17, 1990, but apparently written on January 17, 1991, Dr. Dillon recounted the history of Claimant's workplace injury and subsequent medical treatment. Dr. Dillon reported that Claimant continued to experience low back pain with nerve root irritation with evidence of radicular pain in his left leg, particularly when he was active or attempted to lift or bend. Dr. Dillon noted that Claimant's symptoms had been persistent, causing a decrease in his range of motion, especially with regard to flexion. Dr. Dillon once again opined that Claimant was permanently and totally disabled. (CX. 1, p. 14).

Letter of William R. Knight, M.D.

In a letter to Dr. Dillon, dated May 24, 1990, Dr. William R. Knight, a physical medicine and rehabilitation specialist, reported the results of his physiatric examination of Claimant's chronic back and left lower limb pain. Dr. Knight reviewed the history of Claimant's injury and subsequent medical treatment, noting that after Claimant's first surgery, he returned to light duty work in June 1987 but stopped working in October 1987 when he was unable to continue due to increased pain. A May 1988 lumbar MRI indicated post-surgical changes as well as a central disc herniation with encroachment of the thecal sac and generalized narrowing of the neural canal at L4. Claimant reported constant pain, mostly in the left side radiating into his lower back, buttock, posterior thigh and calf. Claimant experienced frequent leg spasms and was unable to bear full weight on his left limb without discomfort. He was unable to bend, twist or lift without experiencing pain, and he had trouble sleeping. (CX. 1, p. 7). Claimant reported sexual dysfunction and an inability to do daily household activities. (CX. 1, p. 8).

After conducting a physical examination, Dr. Knight's assessment was chronic back pain with history of status post-ruptured L5-S1 disc with left semi-hemilaminectomy and discectomy. Dr. Knight noted that Claimant had significant restriction of lumbar range of motion and reproducible spasms most marked on the left lower aspect of his lumbar spine and buttock, including multiple trigger points. He also observed that Claimant had very hyperactive reflexes. Dr. Knight recommended an EMG and NCS study of Claimant's paraspinal muscles and left lower limb to rule out an ongoing radiculopathy and suggested that Claimant would be a good candidate for a trial of conservative pain control. He recommended physical therapy to mobilize Claimant's restricted back and soft tissues, a trial of TENs under a physical therapist's direction, a gradual stretching program to stretch out spasmed muscles and back school reeducation. Dr. Knight also recommended a conservative trial of appropriate chronic pain medications, including anti-depressants. Dr. Knight suggested that Claimant might benefit from trigger point injections to his spasmed muscles as well as from the use of a lumbosacral orthosis or a warm and form brace. (CX. 1, p. 9).

Letter of Thomas F. Hewes, M.D.

On May 29, 1991, Dr. Hewes, an orthopedic surgeon, wrote a letter to Carrier detailing the results of his recent independent medical examination (IME) of Claimant and summarizing the results of his previous IME of Claimant, on August 8, 1989. Dr. Hewes noted that after completing his initial IME, his impression was that Claimant was post-laminectomy and discectomy on the left at L-5, S-1 with persistent radicular symptoms. At that time, Dr. Hewes had recommended that Claimant undergo a complete work-up, including an MRI and a repeat lumbar myelogram, to determine whether he had further pathology at L4-5 or recurrent pathology at L-5, S-1. Dr. Hewes had felt that Claimant's prognosis was extremely poor and that he had a significant activity restriction

level. Dr. Hewes noted that since that time, Claimant had been seen exclusively by Dr. Dillon, who noted no changes in his symptomatology from at least January 1990 through March 1991. (CX. 2, p. 1). Dr. Hewes also reviewed Dr. Knight's findings and noted that according to Claimant, none of Dr. Knight's recommendations had been followed through, other than the use of the TENs unit. (CX. 2, pp. 1-2).

During Dr. Hewes' May 1991 IME of Claimant, Claimant complained of constant pain which was exacerbated by prolonged sitting or standing. Claimant described pain radiating down his left side all the way to his toes, as well as a twitching sensation in his left leg and an aching pain in his left hip. Claimant told Dr. Hewes that his physical activity was limited to intermittent sitting and walking, such that he could only drive short distances.

Upon physical examination, Dr. Hewes noted that Claimant moved with considerable restricted motion apparently due to pain in the back and lower extremities. Dr. Hewes' impression was that Claimant had a chronic pain syndrome secondary to previous herniated nucleus pulposus and degenerative disc disease with probable post-operative scarring in the affected area. Dr. Hewes felt that Claimant's condition had been stabilized since his last IME in August 1989. He suggested that Claimant be seen by a neurologist because Claimant's pathologic reflexes could not be explained by the previous surgery. Dr. Hewes also recommended a chronic pain treatment program but did not think that surgical intervention was needed. Dr. Hewes opined that Claimant had a fifty percent whole body impairment and loss of physical function to the whole body. (CX. 2, p. 2). He concluded that Claimant had reached MMI and was unable to return to any sort of gainful employment that required prolonged positioning in one position, bending, lifting or driving or riding in a motor vehicle. (CX. 2, pp. 2-3).

Medical Records of Robert R. Smith, M.D.

In a letter to Claimant's attorney, dated October 8, 1992, Dr. Smith, a neurosurgeon, reported that Claimant continued to complain of pain and had a major bulging disc at several levels and some evidence of herniation post-surgery. Claimant's most recent MRI showed that the herniations, which were near the midline, were not massive. Dr. Smith explained to Claimant that due to the high recurrence rate in dealing with discs and Claimant's age, he did not feel that surgery would offer significant relief. On the other hand, if Claimant wanted to proceed with surgery, Dr. Smith would comply because he did not think that surgery would worsen Claimant's condition. Because Claimant expressed some concerns, Dr. Smith advised him to seek a second opinion from a physician specializing in back treatment and gave Claimant the names of several physicians. (CX. 7, p. 70).

In a letter dated December 8, 1993, Dr. Smith wrote to Dr. McKenzie and explained that he had been seeing Claimant since July 1989 for back and leg pain but

could not find anything significantly different about him and had no reason to suggest further diagnostic tests, surgery or other forms of treatment. Dr. Smith thus referred Claimant to Dr. McKenzie for continued follow-up medical care. (CX. 7, p. 65).

On June 11, 1998, Dr. Smith saw Claimant again on a referral from Dr. Lee. Dr. Smith noted that Claimant had experienced neck and shoulder pain off and on for years In April 1998, Claimant had begun to have increased difficulty with the right shoulder radiating into the right arm. Claimant reported numbness and tingling in the thumb and index finger and told Dr. Smith that he did not feel that his condition was improving and that he continued to have difficulty doing activities because of his pain. Although Claimant walked with a cane, his gait was normal with tone in the upper and lower extremities. (CX. 7, p. 61). After examining Claimant, Dr. Smith noted that Claimant had three back discs, with C5-6 being the worst. After discussing the possibility of surgery, Dr. Smith and Claimant agreed to proceed with an anterior cervical discectomy with a bone bank fusion at C5-6, pending approval. (CX. 7, p. 62).

On March 9, 1999, Claimant returned to see Dr. Smith for evaluation and review of films. A lumbar MRI taken that day revealed a bulging disc at L4-5 and L5-S1 but nothing requiring surgical intervention. On physical examination, Claimant had some spasm in the lumbar spine. His upper extremity reflexes were active but present, and in the lower extremity, he had fairly good strength, although he complained of discomfort during the examination. Dr. Smith noted that Claimant had been released with a permanent whole body impairment rating, from the lumbar standpoint, of fifteen percent. Dr. Smith stated that if Claimant's cervical disc problem stemmed from his original injury, he would include a five percent impairment rating for that injury. He prescribed some Celebrex. (CX. 7, p. 59).

On December 20, 1999, Claimant returned to see Dr. Smith, complaining of neck pain radiating into the left arm with tightness in the cervical spine and shoulder, as well as low back pain radiating into the left leg. Claimant reported occasional jumping or jerking motions in his arm. Dr. Smith observed that pain, not limited range of motion, was Claimant's biggest problem. No significant physical changes were noted. Dr. Smith noted that a May 1988 medical report indicated that Claimant had a herniated nucleus pulposus at C7 on the right. He recommended a cervical myelogram and CT scan to determine which level was giving Claimant the most difficulty. (CX. 7, p. 60).

On February 29, 2000, a neurological exam showed tenderness at C5-6, and a myelogram CT of the cervical spine, taken on February 16, 2000, showed some cord compression and pinching of the nerve on the right at C5-6. After a discussion of the surgical risks, Claimant decided to undergo an anterior cervical discectomy and bone bank fusion at C5-6. (CX. 7, p. 30).

On March 17, 2000, Dr. Smith performed an anterior cervical discectomy on Claimant. (CX. 7, p. 27). At the behest of Dr. Smith, Dr. Stephen Faulkner performed an intraoperative consult regarding a right-sided thyroid nodule. On examination, Dr. Faulkner observed a small firm nodule rising from the mid-portion of the right lobe, but there were no palpable lesions on the left side. During surgery, final laceration was performed from the right-sided nodule. Dr. Faulkner recommended that Claimant should be followed up with a thyroid ultrasound once he recovered from his disc surgery. (CX. 7, p. 28).

On May 23, 2000, Claimant returned to Dr. Smith for a post-operative evaluation. Although Claimant's condition had improved somewhat overall, he continued to complain of neck and shoulder discomfort, as well as left hip discomfort. Dr. Smith noted that a thyroid tumor had been removed during the surgery, and he recommended that Claimant follow up with Dr. Faulkner for that condition. Upon physical examination, Claimant's anterior cervical incision was well-healed. He continued to have hyperactive reflexes in the lower extremities. Dr. Smith ordered a lateral view of the cervical spine to evaluate the bone plug and decreased Claimant's daily dose of Oxycontin. (CX. 7, p. 25). This study indicated a triangular density projecting at the anterior margin of the C5-6 disc space and protruding slightly beyond the anterior margin of the vertebral bodies. No other abnormalities were noted. (CX. 7, p. 22).

On July 10, 2000, Claimant's complaints remained largely unchanged. An x-ray indicated that his bone had not yet healed, so he was to return the next day for bone growth stimulation. (CX. 7, p. 24). On July 11, Claimant underwent bone growth stimulation. He was to return in one month. (CX. 7, p. 23).

On October 24, 2000, Claimant reported some improvement in his neck pain but complained of numbness and tingling in the right arm. Dr. Smith noted that a July 2000 cervical MRI revealed a problem at C7-T1. He was concerned about the fact that Claimant was not improving. A lateral C-spine revealed stable appearance of the cervical spine. Claimant was to return as needed. (CX. 7, p. 19).

When Claimant returned to see Dr. Smith on December 12, 2000, the doctor noted that Claimant's last x-ray indicated that his bone fusion was beginning to heal, although it had not completely fused. Claimant had some tightness in the cervical spine but was otherwise neurologically intact. Dr. Smith planned to see Claimant again in two or three months, at which time he hoped Claimant would have reached MMI. Dr. Smith speculated that Claimant would probably be assigned a ten to thirteen percent permanent impairment rating with a fusion, but possibly a higher rating if there were complications or he had a limited range of motion. Claimant was to continue wearing the stimulator and was to undergo another lateral C-spine to check his healing. (CX. 7, p. 18).

On March 15, 2001, Claimant returned to see Dr. Smith. Although he continued to heal, he complained of continued neck pain. His physical examination remained unchanged. The lateral C-spine indicated that Claimant was fusing. Dr. Smith opined that Claimant was "just about" at MMI. He planned to order a functional capacity evaluation (FCE) for Claimant. (CX. 7, p. 14).

On August 21, 2001, Claimant's complaints remained largely the same, and he expressed frustration with his inability to tolerate significant amounts of physical activity without experiencing fatigue. Dr. Smith observed that he had tried numerous treatments to help Claimant, but none of them made a significant difference in his condition. The latest lateral C-spine indicated that Claimant was not totally fused. Dr. Smith noted that Claimant's FCE put him in the medium demand category with specific capabilities. Dr. Smith suggested the possibility of releasing Claimant to work within these restrictions. Dr. Smith stated that although Claimant would have permanent restrictions, he would be glad to support him with rehabilitation or retraining. (CX. 7, p. 13).

On January 28, 2002, Claimant complained that his left hip and left leg pain had increased over the past month. He told Dr. Smith that he had noticed increased low back pain after a big sneeze. Claimant had received a steroid injection at the emergency room but had experienced no relief. Upon physical examination, Claimant had limited range of motion in the lumbar spine, so Dr. Smith recommended a lumbar MRI. (CX. 7, p. 11). On January 31, Dr. Smith reviewed the lumbar MRI results, which indicated a large recurrent extruded disc at L5-S1 on the left side. (CX. 7, p. 9). After a discussion about surgical intervention, Dr. Smith recommended a microlumbar laminectomy and discectomy at L5-S1 on the left side. Claimant indicated that he understood the risks and wished to undergo the procedure, so Dr. Smith planned to seek approval for the operation from Carrier. (CX. 7, p. 10). On February 6, 2002, Dr. Smith performed the surgery. (CX. 7, pp. 7-8).

On March 13, 2002, Claimant complained of increasing weakness in both arms and diminished stamina, but from a lumbar standpoint, his condition was improving. Claimant continued to have hyperactive reflexes and reported some twitching in the biceps and legs. Dr. Smith recommended a cervical MRI with and without contrast. (CX. 7, p. 6). On March 26, Claimant returned for an evaluation of the cervical MRI. The MRI indicated some multi-level disc problems, especially with spurring and foraminal stenosis. There were no signs of cord compression. The bone fusion was stable but not wholly fused. Upon physical examination, Claimant's lumbar spine was intact and well-healed. Dr. Smith recommended conservative management. (CX. 7, p. 4).

On May 9, 2002, Claimant complained of right flank numbness and neck and back pain, especially in the middle of his spine. The physical examination revealed no change in his neurological status, although he did have some tenderness at T11-12. Dr. Smith

recommended MRI of the thoracic spine without contrast. Pending those results, Dr. Smith expected to release Claimant with an impairment rating and permanent restrictions. (CX. 7, p. 3).

On June 24, 2002, Dr. Smith reviewed the results of Claimant's May 31, 2002 thoracic spine MRI, which revealed a disc protrusion at T9 and 10 on the left side, as well as a small disc protrusion at C6-7 and C7-1. Upon physical examination, Claimant exhibited spasm and tightness in the cervical and lumbar spine, as well as scoliosis in the lumbar spine. Straight leg raising was positive on the left at thirty degrees, and reflexes were intact. Dr. Smith recommended a lumbar MRI with and without contrast to make sure that there was no recurrence. (CX. 7, p. 2).

On July 9, 2002, Claimant returned to see Dr. Smith, complaining of a recurrence of left leg pain. He reported having difficulties for the past three weeks for which he received no relief from medication or rest. Claimant had some spasm in his lumbar spine, and his straight leg raising test was again positive on the left at thirty degrees. Motor testing revealed some weakness in the left foot. A July 3, 2002 MRI revealed a new herniated nucleus pulposus at L5-S1 on the left side. Dr. Smith concluded that Claimant would never be able to return to work and should be retired. He planned to try physical therapy in an attempt to relieve Claimant's pain. (CX. 7, p. 1).

Medical Records of Russell L. Blaylock, M.D.

On June 14, 1993, Claimant saw Dr. Blaylock, a neurosurgeon, for a second opinion. Claimant related the history of his workplace injury and subsequent medical treatment. Dr. Blaylock noted that Claimant had treated with Dr. Smith and Dr. Buckley, who had agreed that further surgery would probably not help Claimant's condition. (CX. 4, p. 1). On the day of his appointment with Dr. Blaylock, Claimant complained of constant aching pain down the left leg as well as intermittent neck and left shoulder pain. (CX. 4, pp. 1-2). Claimant had undergone a neck scan which indicated a bulging disc diffusely at C6-7.

After conducting a physical examination, Dr. Blaylock's impression was that Claimant suffered from failed back syndrome. He noted that Claimant had fallen on his buttocks while holding a 100-pound sack and suggested that this injury probably produced some contusion of the nerve root. Claimant had a free fragment with further nerve root damage. Dr. Blaylock felt that Claimant had probably had nerve root pain for so long that surgery would not help with his condition. He told Claimant that although he would not recommend surgery, surgery is always a possibility. Dr. Blaylock opined that Claimant would have to learn to live with his condition and might benefit from a TENs unit. Dr. Blaylock concluded by stating that Claimant probably just needed to be retrained for a different occupation. (CX. 4, p. 2).

Letter of Antronette McKenzie, M.D.

In a letter dated January 31, 1994, Dr. McKenzie, an internist, recounted the history of her treatment of Claimant. Dr. McKenzie reviewed Claimant's history of treatment with other physicians, noting that Claimant had seen Dr. Smith in October 1992. At that time, Dr. Smith gave Claimant the option of undergoing another surgery and suggested a second opinion. Dr. Smith eventually referred Claimant to Dr. McKenzie. Dr. McKenzie first began treating Claimant on July 22, 1993, when he presented at her office with chronic back and leg pain.

In her letter, Dr. McKenzie summarized the findings of an October 1993 physical therapy review of Claimant. She noted that Claimant consistently demonstrated difficulty maintaining a neutral lumbar spine with squatting and other activities. Claimant demonstrated decreased left leg weight-bearing with all standing activities, as well as decreased trunk rotation range of motion and an inability to safely squat greater than one-fourth range. Claimant complained of back, neck, left shoulder or left leg pain with every task. He used a cane for most weight-bearing activities and generally maintained a slight left knee flexion with decreased left leg weight-bearing. (CX. 3, p. 1). Claimant demonstrated a poor quality of movement and an inability to safely perform tested tasks due to his inability to maintain a neutral spine. (CX. 3, pp. 1-2).

Dr. McKenzie concluded by noting that Claimant continued to complain of pain and was unable to engage in any gainful employment despite his years of neurological evaluation and rehabilitation. Claimant continued to seek and require disability status. (CX. 3, p. 2).

Medical Records of Zina Lee, M.D.

May 15, 1995 Letter

In this letter to Claimant's attorney, Dr. Lee, an internist, explained that she had referred Claimant to Dr. Rae for chronic pain management in February 1995 because Claimant's oral narcotics and muscle relaxants did not provide sufficient relief of his symptoms. (CX. 5, p. 13).

July 30, 1996 Note

In this note, Dr. Lee explained that she was treating Claimant for chronic lower back pain, lumbar disc disease and depression. Because Claimant was in a lot of pain, Dr. Lee referred him to Dr. Vohra for pain management. (CX. 5, p. 10).

January 6, 1999 Note

In this note, Dr. Lee, summarized Claimant's course of treatment with her. Dr. Lee had treated Claimant since August 1994. During this course of treatment, Claimant had also seen Dr. Rae, an anesthesiologist, since 1995 for pain management. In addition, Dr. Rae had treated Claimant for depression. At some point, Claimant had received epidural nerve blocks in his lumbar area to treat his chronic lower back pain, but he reported no relief from this treatment. Claimant had seen Dr. Vohra for pain management and reported only intermittent relief. According to Dr. Lee, Claimant started complaining of right shoulder and neck pain in the latter part of 1995. A May 1998 MRI revealed a disc protrusion at C5-6. Claimant was referred to Dr. Smith for evaluation of his severe disc disease of the cervical spine and was offered a possible cervical laminectomy, which Carrier refused to approve. Claimant suffered from chronic depression secondary to his chronic pain and wished to return to work if he could find a way to relieve his pain. On Claimant's most recent visit to Dr. Lee's office, he had been offered outpatient referral for psychiatric counseling to help him better deal with his chronic pain and depression. (CX. 5, p. 6). Dr. Lee considered Claimant to be disabled secondary to severe degenerative joint disease and disc disease of the neck as well as chronic lower back pain. (CX. 5, p. 7).

Medical Records of Rahul Vohra, M.D.

Dr. Vohra, a pain management specialist, first saw Claimant on a referral from Dr. Lee on August 21, 1996. Dr. Vohra reviewed the history of Claimant's workplace injury and subsequent medical treatment, noting that Claimant had seen many doctors since undergoing surgery and had undergone physical therapy on multiple occasions without experiencing relief from his symptoms. Claimant presented to Dr. Vohra with complaints of chronic low back pain and left lower extremity pain. Claimant told Dr. Vohra that his pain increased with any type of movement and decreased when he was lying down. (CX. 6, p. 3). After examining Claimant, Dr. Vohra's impression was that Claimant's pain was multi-factorial in nature, with a component of left S1 joint pain, some mechanical low back pain and possibly some chronic radicular pain. Dr. Vohra told Claimant that it would be difficult to effect a remarkable change in his pain due to the chronicity of his problems, but he hoped to make Claimant more functional. Dr. Vohra increased Claimant's daily dose of Neurontin and planned to consider a diagnostic left S1 joint injection. Dr. Vohra explained that if this injection relieved Claimant's pain, Claimant might be a candidate for a short course of therapy to address his S1 joint, but if not, another course of physical therapy probably would not be productive. (CX. 6, p. 4).

In a letter to Claimant's attorney, dated June 12, 1997, Dr. Vohra reviewed his treatment of Claimant. He reported that although he had attempted to control Claimant's pain through the use of several different medications, this course of treatment was unsuccessful. Dr. Vohra explained that in December 1996, Claimant began to complain

of increased left lower extremity pain, and an MRI revealed disc protrusion at L4-5. Dr. Vohra felt that EMG/nerve conduction studies were needed, but Carrier refused to authorize this expense. Because Claimant continued to complain of back pain, Dr. Vohra referred him to Dr. Lon Alexander, a neurosurgeon. Dr. Vohra had not seen Claimant since April 1997 and did not know whether Claimant had ever consulted with Dr. Alexander. (CX. 6, p. 5).

On August 11, 1997, Claimant reported that he had gone to the emergency room the week before because of severe shoulder pain. Claimant told Dr. Vohra that he had suffered from intermittent shoulder pain since his workplace accident, although he had never before mentioned it to Dr. Vohra. On physical examination, Claimant had good cervical range and good active and passive range of motion in his shoulder. Impingement signs were positive, while a drop arm was negative. Claimant had some weakness with supraspinatus strength testing, and his relocation test was positive. His lumbar exam was unchanged. Dr. Vohra planned to order a shoulder MRI and attempt to obtain authorization for the EMG/nerve conduction studies. (CX. 7, p. 52).

Dr. Vohra saw Claimant for the last time on September 4, 1997. He noted that Claimant's EMG/nerve conduction studies revealed a chronic left L5 radiculopathy but nothing looked acute. Dr. Vohra told Claimant that he did not have any more treatment to offer him, nor did he think surgery would be beneficial for Claimant. Dr. Vohra opined that Claimant had reached MMI with a ten percent impairment rating. (CX. 6, p. 1).

Letter of Edward S. Kaplan, M.D.

Dr. Lee referred Claimant to Dr. Kaplan for a neurological consult. (CX. 5, p. 1). Dr. Kaplan reviewed the history of Claimant's injury and subsequent medical treatment in some detail, noting that although Dr. Smith offered Claimant a C5-6 discectomy on the right in 1998, Carrier refused to authorize this surgery because it did not believe that the neck injury was causally related to Claimant's workplace injury. (CX. 5, pp. 1-2). Claimant, by contrast, stated that he had been having neck pains and alternating shoulder pains ever since his original injury occurred.

When Dr. Kaplan examined Claimant on May 28, 1999, Claimant had normal strength, sensation and reflexes. He had a demonstrative limp on the left lower extremity and brought a cane, although he did not need a cane for walking. Dr. Kaplan observed that testing upper extremity strength allegedly produced left lower extremity pains and also noted frequent grunting, sighing, pain expressions and pain behavior. The variability of cervical range of motion suggested some guarding, and there was moderate limitation of cervical lateral movement and extension and mild limitation of cervical flexion. Dr. Kaplan observed that Claimant moved his neck "rather fully to each side" when

searching for the bathroom. There was no cervical spasm or tenderness. Dr. Kaplan summarized the findings of Claimant's various MRIs.

Dr. Kaplan's impressions were status post-L5-S1 discectomy on the left, lumbar degenerative joint disease at L4-L5 and L5-S1, chronic pain syndrome, pain expressions, pain behavior and inconsistencies on examination. Dr. Kaplan thought that Claimant's C5-6 disc herniation on the right had probably occurred sometime between May 26, 1988, and May 21, 1998. Claimant suffered from cervical osteoarthritis and degenerative joint disease, as well as depression and anxiety. (CX. 5, p. 3). Dr. Kaplan and Claimant discussed Claimant's objectively confirmed disease, pain behavior, pain expressions, inconsistencies on examination, depression and anxiety. Dr. Kaplan told Claimant that if he wanted to pursue his cervical disc herniation, he should consider myelography/CT scans. Dr. Kaplan felt that Claimant was a candidate for cervical disc surgery, particularly for the right side C5-6 herniation. Based on Claimant's examination and lumbar MRIs, Dr. Kaplan did not feel that Claimant needed lumbar surgery. (CX. 5, p. 4).

III. DISCUSSION

In arriving at a decision in this matter, it is well-settled that the fact-finder is entitled to determine the credibility of the witnesses, weigh the evidence and draw his own inferences from it and is not bound to accept the opinion or theory of any particular medical examiner. Todd Shipyards v. Donovan, 200 F.2d 741 (5th Cir. 1962); Atlantic Marine, Inc. and Hartford Accident & Indem. Co. v. Bruce, 666 F.2d 898, 900 (5th Cir. 1981); Banks v. Chicago Grain Trimmers Ass'n, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 928 (1968). It has been consistently held that the Act must be construed liberally in favor of the claimants. Voris v. Eikel, 346 U.S. 328, 333 (1953); J.B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967).

However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the claimant when evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d), which specifies the proponent of a rule or position has the burden of proof. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994), aff'g 990 F.2d 730 (3d Cir. 1993).

I found Claimant in this case to be a credible witness and I have weighed his testimony accordingly.

Causation

Section 20(a) of the Act provides the claimant with a presumption that his disabling condition is causally related to his employment if he shows he suffered a harm and employment conditions existed which could have caused, aggravated or accelerated

the condition. Gencarelle v. General Dynamics Corp., 22 BRBS 170 (1989), aff'd, 892 F.2d 173, 23 BRBS 13 (CRT) (2d Cir. 1989). Once the claimant proves these elements, the claimant has established a prima facie case and is entitled to a presumption that the injury arose out of the employment. Keliata v. Triple Machine Shop, 13 BRBS 326 (1981); Adams v. General Dynamics Corp., 17 BRBS 258 (1985). With the establishment of a prima facie case, the burden shifts to the employer to rebut the presumption with substantial countervailing evidence. James v. Pate Stevedoring Co., 22 BRBS 271 (1989). If the presumption is rebutted, the administrative law judge must weigh all the evidence and render a decision supported by substantial evidence. Del Vecchio v. Bowers, 296 U.S. 280 (1935).

An injury occurs when something unexpectedly goes wrong within the human frame. Wheatley v. Adler, 407 F.2d 307 (D.C. Cir. 1968). An external, unforeseen incident is not necessary; experiencing back pain or chest pain at work can be sufficient. Darnell v. Bell Helicopter Int'l Inc., 16 BRBS 98 (1984). If an employment-related injury contributes to, combines with or aggravates a pre-existing disease or underlying condition, the entire resultant condition is compensable. The relative contributions of the work-related injury and prior condition are not weighted in determining the claimant's entitlement ("aggravation rule"). Wheatley, 407 F.2d at 307.

It is undisputed that Claimant suffered a workplace accident on August 4, 1986, when he was lifting a 100-pound sack and felt his back pop. Claimant testified that he felt sharp pain in his low back and down his left side as well as in his neck. However, in 1998, Carrier reduced Claimant's compensation benefits based upon its belief that Claimant's neck injuries were not causally related to his workplace accident. According to the medical records, the first mention of Claimant's neck pain occurred in 1987, when Claimant reported neck pain to Dr. John Neill. Dr. Blaylock also reported neck pain in 1993. At that time, Claimant complained of intermittent neck and left shoulder pain. In an October 1993 physical therapy review, Claimant complained of neck and left shoulder pain. Dr. Lee, who began treating Claimant in 1994, first noted Claimant's complaints of right shoulder and neck pain in the latter part of 1995. A May 1998 MRI revealed a disc protrusion at C5-6, so Claimant was referred back to Dr. Smith, a neurosurgeon who had treated Claimant on an intermittent basis since July 1989. On June 11, 1998, Dr. Smith noted that Claimant had experienced neck and shoulder pain off and on for years. In December 1999, Dr. Smith observed that a May 1988 medical report had indicated that Claimant had a herniated nucleus pulposus at C7 on the right.

While Claimant's initial course of treatment in the first years after his injury was primarily focused on his back and left leg pain, the medical records indicate that there was evidence of objective problems in his neck at least as far back as May 1988. In addition, several doctors noted Claimant's neck complaints in the early 1990s, well before Carrier determined that the neck injury was unrelated to his workplace accident. Furthermore, there is no evidence in the record to indicate that Claimant, who has not

worked since October 1987, sustained some sort of superceding injury that would sever the causal link between his workplace accident and his later development of neck problems, and according to the medical records, none of the doctors ever intimated that Claimant's neck injury was a separate condition apart from his work-related injuries. I find that Claimant has established a prima facie case that his neck problems are causally related to his August 4, 1986 workplace injury.

Once the presumption is invoked, the burden shifts to the employer to rebut the presumption by presenting substantial countervailing evidence that the injury was not caused by the employment. See 33 U.S.C. § 920(a). The Fifth Circuit addressed the issue of what an employer must do in order to rebut a Claimant's prima facie case in Conoco v. Director, OWCP, 194 F.3d 684 (5th Cir. 1999). In that case, the Fifth Circuit held that to rebut the presumption, an employer does not have to present specific and comprehensive evidence ruling out a causal relationship between the claimant's employment and his injury. Rather, to rebut a prima facie presumption of causation, the employer must present substantial evidence that the injury is not caused by the employment. Noble Drilling v. Drake, 795 F.2d 478 (5th Cir. 1986), cited in Conoco, 194 F.3d at 690.

As a result of a successful rebuttal of the presumption by the employer, the fact finder must evaluate the record evidence as a whole in order to resolve the issue of whether or not the claim falls within the Act. Del Vecchio v. Bowers, 296 U.S. 280 (1935); Volpe v. Northeast Marine Terminals, 671 F.2d 697 (2d Cir. 1982). The Court must weigh all the evidence in the record and render a decision supported by substantial evidence. See Del Vecchio, 296 U.S. 280 (1935).

In this case, Carrier did not appear at the hearing nor did Carrier submit any evidence to justify its decision to reduce Claimant's compensation benefits due to the absence of a causal link between his neck injury and his workplace accident. I noted as well that Carrier never requested modification before reducing Claimant's benefits. In any case, there is no evidence that Claimant's neck injury was due to a subsequent, non-work-related event or an intervening cause. Consequently, Carrier has failed to rebut Claimant's prima facie case that his neck condition is causally related to his workplace accident. I find that causation exists as to Claimant's neck problems.

Nature and Extent

Having established work-related injuries, the burden rests with the claimant to prove the nature and extent of his disability, if any, from those injuries. Trask v. Lockheed Shipbldg. Constr. Co., 17 BRBS 56, 59 (1985). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement (MMI). James v. Pate Stevedoring Co., 22 BRBS 271, 274 (1989); Trask, 17 BRBS at 60. Any disability before reaching MMI would thus be temporary in nature.

The date of MMI is a question of fact based upon the medical evidence of record. Ballestros v. Willamette W. Corp., 20 BRBS 184 (1988); Williams v. General Dynamics Corp., 10 BRBS 915 (1979). An employee reaches MMI when his condition becomes stabilized. Cherry v. Newport News Shipbldg. & Dry Dock Co., 8 BRBS 857 (1978); Thompson v. Quinton Enter., Ltd., 14 BRBS 395 (1981). The mere possibility of future surgery, by itself, does not preclude a finding that a condition is permanent. Worthington v. Newport News Shipbldg. & Dry Dock, 18 BRBS 200, 202 (1986).

According to the medical records in this case, Dr. Dillon, who was at that time Claimant's treating physician, determined that Claimant had reached MMI on June 2, 1989. Although he noted that Claimant would probably need another surgery, Dr. Dillon did not specify what type of surgery might be required or when the surgery might be performed. Over a year later, on October 23, 1990, Dr. Dillon opined that Claimant was permanently and totally disabled for any and all kinds of gainful employment. I find that Claimant reached MMI for the first time on June 2, 1989.

On June 11, 1998, Dr. Smith, Claimant's treating neurosurgeon, first recommended another surgery for Claimant, who had previously undergone one surgery in February 1987. Claimant underwent this surgery on March 17, 2000, and later underwent a third surgery on February 6, 2002. On July 9, 2002, Dr. Smith determined that Claimant would never be able to return to work and should be retired. I find that Claimant reached MMI for the second time on July 9, 2002.

The question of extent of disability is an economic as well as a medical concept. Quick v. Martin, 397 F.2d 644 (D.C. Cir. 1968); Eastern S.S. Lines v. Monahan, 110 F.2d 840 (1st Cir. 1940). Disability under the Act means an incapacity, as a result of injury, to earn wages which the employee was receiving at the time of the injury at the same or any other employment. 33 U.S.C. § 902(10). In order for a claimant to receive a disability award, he must have an economic loss coupled with a physical or psychological impairment. Sproull v. Stevedoring Servs. of America, 25 BRBS 100, 110 (1991). Economic disability includes both current economic harm and the potential economic harm resulting from the potential result of a present injury on market opportunities in the future. Metropolitan Stevedore Co. v. Rambo (Rambo II), 521 U.S. 121, 122 (1997). A claimant will be found to have either no loss of wage-earning capacity, no present loss but a reasonable expectation of future loss (de minimis), a total loss or a partial loss.

A claimant who shows he is unable to return to his former employment has established a prima facie case for total disability. The burden then shifts to the employer to show the existence of suitable alternative employment. P & M Crane v. Hayes, 930 F.2d 424, 430 (5th Cir. 1991); New Orleans (Gulfwide) Stevedores v. Turner, 661 F.2d 1031, 1038 (5th Cir. 1981). Furthermore, a claimant who establishes an inability to return to his usual employment is entitled to an award of total compensation until the date

on which the employer demonstrates the availability of suitable alternative employment. Rinaldi v. General Dynamics Corp., 25 BRBS 128 (1991).

When Dr. Dillon placed Claimant at MMI on June 2, 1989, he stated that Claimant was unable to return to his previous employment, even with restrictions. Dr. Dillon later stated that Claimant was permanently and totally disabled for any type of gainful employment. Carrier has produced no evidence as to the availability of suitable alternative employment for Claimant after June 2, 1989.[1] I find that Claimant was permanently totally disabled from June 2, 1989, until March 17, 2000. Employer/Carrier shall pay Claimant temporary total disability compensation from January 3, 1987, through June 1, 1989, based on an average weekly wage of $670.63. Employer/Carrier shall pay Claimant permanent total disability compensation from June 2, 1989, through March 16, 2000, based on an average weekly wage of $670.63.

On July 9, 2002, when Dr. Smith determined that Claimant had reached MMI, he concluded that Claimant would never be able to return to work and should be retired. Carrier has produced no evidence as to the availability of suitable alternative employment for Claimant after July 9, 2002. I find that Claimant has been permanently totally disabled since July 9, 2002. Employer/Carrier shall pay Claimant temporary total disability compensation from March 17, 2000, through July 8, 2002, based on an average weekly wage of $670.63. Employer/Carrier shall pay Claimant permanent total disability compensation commencing on July 9, 2002, and continuing, based on an average weekly wage of $670.63.[2]

Section 22 Modification of Benefits

Section 22 of the Act states that any party-in-interest may, within one year of the last payment of compensation or rejection of a claim, request modification of a compensation award for mistake of fact or change in condition. 33 U.S.C. § 922. Modification based upon a change in condition is granted where the claimant's physical condition has improved or deteriorated following entry of the award but before the request for modification. See Rizzi v. Four Boro Contracting Corp., 1 BRBS 130 (1974). Where a party seeks modification based on a change in condition, an initial determination must be made as to whether the petitioning party has met the threshold requirement by offering evidence demonstrating that there has been a change in the claimant's condition. Jensen v. Weeks Marine, Inc. (Jensen II), 34 BRBS 147 (2000), decision and order on remand at 35 BRBS 174 (2001). This initial inquiry does not involve a weighing of the relevant evidence of record, but rather is limited to a consideration of whether the newly

[1] While the record does indicate that Carrier conducted a labor market survey in 1994 and used these results as a basis for reducing Claimant's compensation benefits, the record does not contain the labor market survey itself. (CX. 12, p. 8).

[2] Section 10(f) adjustment shall apply.

submitted evidence is sufficient to bring the claim within the scope of Section 22. If so, the ALJ must determine whether modification is warranted by considering all of the relevant evidence of record to discern whether there was, in fact, a change in the claimant's physical or economic condition from the time of the initial award to the time modification is sought. Once the petitioner meets the initial burden of demonstrating a basis for modification, the standards for determining the extent of disability are the same as in the initial proceeding.

The party requesting modification has the burden of proof in showing a change in condition. See Vasquez v. Continental Maritime of San Francisco, Inc., 23 BRBS 428 (1990); Winston v. Ingalls Shipbldg., Inc., 16 BRBS 168 (1984). The Section 20(a) presumption is inapplicable to the issue of whether a claimant's condition has changed since the prior award. Leach v. Thompson's Dairy, Inc., 6 BRBS 184 (1977).

Awards of benefits based upon agreements and stipulations of the parties are subject to Section 22 modification because they do not provide for the compete discharge of employer's liability or terminate claimant's right to benefits. See Lawrence v. Toledo Lake Front Docks, 21 BRBS 282 (1988); Ramos v. Global Terminal & Container Servs., Inc., 34 BRBS 83 (2000) (compensation order issued by district director and based on stipulations can subsequently be modified via a § 22 modification request).

At the hearing, Claimant's attorney explained that there had been a previous hearing in this matter. At that hearing, which apparently took place at some point during 1990, the Parties stipulated to the average weekly wage and Employer/Carrier agreed to pay Claimant compensation benefits according to the stipulated wage. (Tr. 30). The case was remanded to the District Director, and the administrative law judge entered an Order approving the stipulations and awarding attorney's fees. (Tr. 30-31).

In a letter to Claimant's attorney dated May 9, 1994, an employee from Carrier's claims department indicated that a labor market survey had been performed by a rehabilitation counselor and approved by Dr. Blaylock, who the letter referred to as Claimant's "treating physician." As per the labor market survey, Carrier determined that Claimant's compensation rate was to be reduced to $333.75 per week based on his loss of wage-earning capacity. (CX. 12, p. 8). According to Claimant's testimony, Carrier subsequently reduced Claimant's compensation benefits on August 9, 1994. However, the record contains no evidence of the labor market survey, nor is the survey mentioned in any of the medical records provided by Claimant. In addition, the record indicates that Dr. Blaylock only saw Claimant on one occasion, for a second opinion, and was never Claimant's treating physician. There is no evidence, other than the letter, to suggest that Dr. Blaylock signed off on this survey. Most importantly, there is no evidence that Carrier ever requested modification of Claimant's previous award of compensation benefits based on this labor market survey. In addition, Claimant testified that his benefits were reduced a second time in 1998, when Carrier decided that his neck injury

was not causally related to his workplace accident. Claimant's attorney informed the Court that when Claimant's benefits were reduced for the first time, he filed an objection and began to write letters to Carrier attempting to resolve this issue. (Tr. 32; CX. 7, p. 38). After Claimant's benefits were again reduced, Claimant's attorney continued to write letters to Carrier attempting to resolve the compensation issue. (CX. 7, pp. 15, 35; CX. 12, pp. 1, 3, 5, 6).

Since Carrier never requested modification of Claimant's award, it was not authorized to unilaterally reduce his compensation benefits in 1994 or 1998. Needless to say, Carrier has not met its burden of proof in showing a change in Claimant's condition. Instead, it has repeatedly ignored Claimant's numerous attempts to resolve the compensation issue. I find that Claimant's compensation benefits have remained at the stipulated amount of $447.09 per week at all times since the issuance of the first Order in this case subject to Section 10(f) adjustments.

Medical Expenses

Section 7 of the LHWCA provides in pertinent part: "The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). In order to assess medical expenses against an employer, the expenses must be reasonable and necessary. Pernell v. Capital Hill Masonry, 11 BRBS 582 (1979).

Costs incurred for transportation for medical purposes are recoverable under Section 7(a). Day v. Ship Shape Maintenance Co., 16 BRBS 38 (1983). The Board has noted 20 C.F.R. § 702.403 in cases dealing with reimburseable travel expenses. The regulation states in pertinent part that "[g]enerally, 25 miles from the place of injury or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into account." In Nides v. 1789, Inc., (BRB No. 99-0162 (Oct. 18, 1999) (unpublished), the Board held that when the employer did not challenge the claimant's credibility regarding travel records, the administrative law judge should sustain those costs. The Board noted 20 C.F.R. § 702.401(a), which defines medical care, in pertinent part, as including "the reasonable and necessary cost of travel . . . which is recognized as appropriate by the medical profession for the care and treatment of [claimant's] injury or disease."

Claimant seeks reimbursement for mileage accrued during his trips to see Drs. Smith, Vohra, Kaplan and Blaylock. Claimant's trips to see Drs. Smith, Vohra and Blaylock each involved 174 miles of travel roundtrip, while his trip to Dr. Kaplan's office involved 560 miles of travel roundtrip. (CX. 8, p. 1). Although these distances are all significantly greater than twenty-five miles, the Board has previously held an employer liable for a claimant's mileage and travel costs associated with treatment for a work

injury which involved traveling 197 miles roundtrip. Reed v. Jamestown Metal Marine (BRB No. 97-881) (Mar. 23, 1998) (unpublished). It is clear from the regulations and the case law that the administrative law judge has discretion in approving mileage expenses, even when the claimant must travel a great distance for medical treatment. Since Carrier has provided no argument as to why the mileage expenses in question should not be approved, I find that these mileage expenses were a reasonable and necessary part of Claimant's medical treatment. Carrier shall reimburse Claimant for all mileage expenses associated with Claimant's treatment by Drs. Smith, Vohra, Kaplan and Blaylock, as provided in the record.

Claimant testified that since the death of his treating neurosurgeon, Dr. Smith, Carrier has refused to authorize treatment with another neurosurgeon. Claimant has requested authorization to treat with a neurosurgeon of his choice. As the record reflects, Claimant is permanently and totally disabled, has multiple back and neck problems and will likely suffer from chronic pain for the rest of his life. Given Claimant's condition, I find that treatment with a neurosurgeon is a reasonable and necessary medical expense. Carrier shall pay for all reasonable and necessary medical expenses associated with the treatment of Claimant's various medical problems, including his back, neck and leg pain, by Claimant's choice of neurosurgeon. Carrier shall also be responsible for payment of any previously unpaid medical expenses relating to the treatment of Claimant's work-related injuries.

Conclusion

Based on the foregoing findings of fact, conclusions of law and the entire record, I hereby enter the following compensation order. All other issues not decided herein were rendered moot by the above findings.

ORDER

It is hereby ORDERED, ADJUDGED AND DECREED that:

1. Employer/Carrier shall pay Claimant temporary total disability compensation for the time period from January 3, 1987, through June 1, 1989, based on an average weekly wage of $670.63, with a corresponding compensation rate of $447.09 per week.

2. Employer/Carrier shall pay Claimant permanent total disability compensation from June 2, 1989, through March 16, 2000, based on an average weekly wage of $670.63.

3. Employer/Carrier shall pay Claimant temporary total disability compensation from March 17, 2000, through July 8, 2002, based on an average weekly wage of $670.63.

4. Employer/Carrier shall pay Claimant permanent total disability compensation commencing on July 9, 2002, and continuing, based on an average weekly wage of $670.63.

5. The adjustments provided by Section 10(f) shall apply.

6. Employer/Carrier shall pay all reasonable and necessary medical expenses related to the treatment of Claimant's injuries which are causally related to his August 4, 1986 workplace accident, including reimbursement for mileage accrued in Claimant's travel to and from Dr. Smith's office, Dr. Vohra's office, Dr. Kaplan's office and Dr. Blaylock's office, as well as any previously unpaid medical expenses relating to the treatment of these injuries.

7. Employer/Carrier shall authorize Claimant's treatment with a neurosurgeon of his choice for all of Claimant's injuries which are causally related to his August 4, 1986 workplace accident, including his neck injuries.

8. Employer/Carrier shall receive a credit for benefits and wages paid.

9. Employer/Carrier shall pay Claimant interest on any accrued unpaid compensation benefits at the rate provided by 28 U.S.C. § 1961.

10. Within thirty days of receipt of this Order, counsel for Claimant should submit a fully-documented fee application, a copy of which shall be sent to Carrier, who shall have twenty days to respond.

11. All computations of benefits and other calculations which may be provided for in this order are subject to verification and adjustment by the District Director.

ORDERED this 29th day of October, 2003, at Metairie, Louisiana.

A

LARRY W. PRICE
Administrative Law Judge

LWP:bbd